


CASE MANAGEMENT

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
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Legislation

- As required by **Section 10.68A (a) (10)** DHHS has undertaken a review of all case management services reimbursed by Medicaid in order to develop a plan for consolidation.
 - \$40 million reduction associated with the consolidation plan

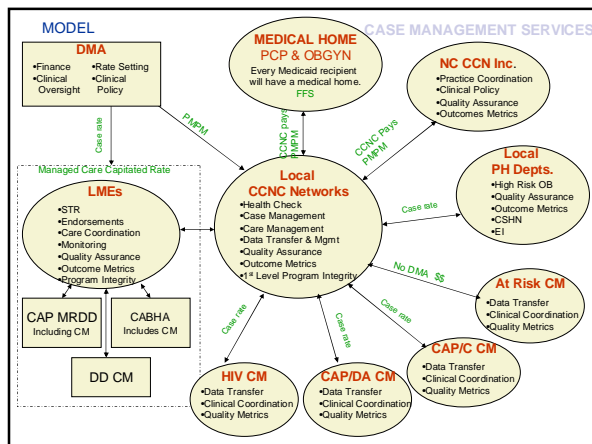
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Highlights of Previous Presentations

- Previous presentations made in October and November, 2009 and covered:
 - An overview of the case management and care management definition and the 4 functions of case management
 - The current target populations covered
 - Data regarding program recipients and costs
 - Cost savings estimated if implemented January 1
 - \$10-13 m for unit limitation
 - \$2.5 m for single case manager
 - The work of the Steering Committee
 - Desired Outcomes/Goals
 - The short and long term goals
 - The diagram of the organizational structure
 - Next steps

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Short Term Goals

- Unit Limits on case management – effective 3/1/10 (3hrs per month, 6 hrs “pool” per year)
 - Children are eligible for EPSDT reviews
 - PAG notification was January, 2009
 - Publication in Implementation Memo and Medicaid Bulletin January and Feb, 2009
 - Notification to recipients January 25, 2009
 - Prior authorized units were allowed to continue until time for next authorization or renewal
- Eliminate prior authorizations on CAP-MRDD case management – effective 3/1/10 (administrative reduction)
- Reduce prior authorizations on non waiver DD case management from quarterly to annually – effective 4/1/10 (administrative reduction). Will be closely monitored

Short Term Goals

- Allow direct billing for CAP DME waiver supplies – effective 7/1/10 (administrative reduction)
- Eliminate duplication – effective 4/1/10
 - Place audits in system where possible to prevent billing by more than one CM provider in the same month
- *Also reported that DHHS would continue to involve stakeholders in the implementation/operations of the next steps and long term planning*

Operations and Implementation

- Stakeholder involvement in operations and implementation – have been meeting weekly since 1/19/10 with regular debriefing with DMA Management
- Representatives from providers, advocacy groups, consumers, DHHS division staff
- Four workgroups created to work on long term strategies and action steps: Service definition, CAP Waiver Standardization, CCNC Linkages, Form Standardization
 - Implementation strategy and plan
 - Timeline for implementation
 - Transition plan for current recipients and providers
 - Training plan
- Final Deliverables due 3/26/10

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Service Definition Workgroup

As of January 2006, there is one federal definition for targeted case management which consists of 4 functions. However, today NC CM programs have different policies and procedures. This workgroup is charged with creating one standard policy.

- Target Populations
 - Entrance, Continued Stay and Exit Criteria – there will be similarities and differences among disability areas
 - Case Manager Qualifications for staff
 - Provider Qualifications
 - Outcomes
- **As long as targeted case management is the service billed, administrative functions MAY NOT be billed as TCM – only the 4 functions.**

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Steering Committee Goals/Outcomes Addressed

- Ensure timely and accurate needs assessment
- Implement client specific outcomes
- Maintain disability/need specific expertise
- Prevention of substandard service delivery
- Develop professional standards for case managers
- Simplify the maze of various types of case management services and systems
- Develop a payment structure to promote outcomes
- Coordinate with programs such as Part C of IDEA or Title V and other DHHS funding sources.

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CAP Waiver Standardization

CAP Waiver programs (1915c) are all regulated by the same federal guidelines yet their policies and procedures are different. This workgroup is charged with identifying areas that the three waivers can be made consistent. In addition they are looking at ways to simplify administration of the waivers.

- Identification of any Waiver requirements that may not be covered as allowed in direct TCM

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Steering Committee Goals/Outcomes Addressed

- Simplify and eliminate ineffective administrative processes where allowed by regulation
- Simplify the maze of various types of case management services and systems
- Maintain disability/need specific expertise
- Prevention of substandard service delivery

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CCNC Linkages

Data sharing is critical for coordinating clinical care. This workgroup is charged with developing processes and agreements that allow for key medical and behavioral information to be provided for all Medicaid recipients at the point of care. This data is needed to provide analytical support to prevent service duplication and optimize coordination of care.

- Which agency assumes primary responsibility and accountability – MH/DD/SA triggers such as:
 - ☐ Inpatient state or private
 - ☐ Use of Crisis services
 - ☐ History of 3 or more ED visits as well as prevention/diversion
 - ☐ Pharmacy/medication issues
 - ☐ NCQA standards for complex case management
- Communication linkages –data agreements
 - ☐ CCNC and LMEs for MH/DD/SA – meeting regularly with representation of LMEs, CCNC and DMA/DMH staff
 - ☐ CCNC and DPH for pregnancy home
 - ☐ CCNC and other waivers and medical

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Steering Committee Goals/Outcomes Addressed

- Ensure appropriate linkages and follow up to services
- Eliminate duplication of functions and increase coordination /integration
- Support development of interoperable medical record systems
- Data sharing with providers

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Forms Standardization

Since each case management program today has its own policies and procedures, they also have their own unique set of forms. This workgroup is charged with creating a standard set of forms/elements to be used by case managers.

- ☐ Coordination with initiatives for standardization

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Steering Committee Goals/Outcomes Addressed

- Simplify and eliminate ineffective administrative processes
- Support the development of interoperable medical record system

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Next Steps

- DD TCM submitted in 2005 approved by CMS 2/27/10. Still waiting on approval of the HIV SPA.
- CMS would not allow NC to submit the integrated CM SPA until the 2005 DD TCM was approved and the HIV SPA is approved
- CMS is requiring that the new SPA address all outstanding compliance issues such as cost reports for public agencies, comparability of TCM services and rates among various programs, and adherence to TCM SPA template requirements
- Revise payment structure – Case rate is under actuarial review by Mercer. The MH/SA case rate includes CABHA requirements as currently written. Other case rate includes waiver and non MH/SA TCM. Until actuarially certified and approved by CMS, the rates will not be valid.
 - Explanation of case rate
- SPA submission is scheduled in March
- Policy is more detailed and actually addresses more of the day to day operations. Draft policy posted 3/8/09. Draft is scheduled for the March/April Physician's Advisory Group (PAG)

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Next Steps

- Submit CAP waiver revisions to CMS to make program policies more consistent
- Coordinate the MH/SA/DD implementation with other activities such as CABHA roll out, DD TCM direct enrollment since 05 SPA is approved, RFP submission and review for 1915b/c waiver
- Coordinate Community Support Phase Out
 - As of January 1, only Q (the case management function) of CS could be provided for new admissions and as a means to continue the needed CM for existing recipients.

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